Quality, Innovation, Productivity and Prevention (QIPP) and Personal Health Budgets

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Acknowledgements

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Introduction

In light of the economic downturn and reductions in public spending, the NHS faces a significant challenge in creating efficiency savings. Efficiency in the NHS can be improved both by reducing the cost of providing a service and by improving the quality of a service without increasing its cost.

Personal health budgets are a recent innovation in the NHS. This paper discusses the extent to which they may contribute to improving efficiency in the health service. The paper identifies the following seven areas where PHBs could contribute to efficiency gains in the NHS:

- improving shared decision-making and responsiveness to individual needs;
- improving health outcomes through genuine co-production;
- developing alternative, less costly packages of care;
- reducing overall service utilisation through greater prevention;
- increasing competition between providers;
- improving coordination between services; and
- changing professional roles.
Background

From the 1997 financial year to the 2010 financial year the NHS budget grew in real terms at, on average, 5.7 percent per year. The Comprehensive Spending Review in October 2010 announced a 0.4 percent real-terms increase in spending for the next three years beginning in the 2011 financial year. Analysis by the Kings Fund and Institute for Fiscal Studies suggests that the NHS would require a real-terms increase of at least 1.1 percent per year between now and 2017 just to meet demographic pressures while maintaining current quality standards (Appleby et al., 2009). This means that the NHS will face a gap in spending between the 2011 and the 2013 financial years of between £15 billion and £30 billion, depending on estimates. This will have to be made up through efficiency savings.

To support the NHS locally to deliver efficiency savings, the Department of Health launched the Quality, Innovation, Productivity and Prevention (QIPP) programme in 2009. The purpose of the programme is to support commissioners and providers to develop service improvement and redesign initiatives that improve productivity, eliminate waste and drive up clinical quality (DoH, 2010b). QIPP has 12 priority work streams that fit into three categories: commissioning; providers; and supporting work streams (see QIPP work streams box). The recent health White Paper, Equity and Excellence: Liberating the NHS, provides continuing support for the QIPP programme, arguing for renewed urgency and a greater focus on general practice leadership, reflecting the shift in commissioning responsibilities from PCTs to GP consortia by financial year 2012 (DoH, 2010a).
### QIPP work streams

#### Commissioning work streams

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<thead>
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<th>1. Long-term conditions</th>
<th>Reduce unplanned admissions by 20%</th>
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<td>2. Urgent and emergency care</td>
<td>Prevent 10% A&amp;E attendances; 20,000 ambulance journeys</td>
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<td>3. End of life care</td>
<td>Increase proportion of deaths outside hospital; decrease complaints through better bereavement services</td>
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<td>4. Right care</td>
<td>Reduce unwarranted variation between PCTs; shared decision making; decommissioning lower value interventions</td>
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<td>5. Safe care</td>
<td>Reduce bed ulcers by 80%; moderate/serious harm from falls by 50%; catheter urinary tract infections by 50%</td>
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#### Provider work streams

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<th>6. Procurement</th>
<th>Reduce and optimise non-pay expenditure for NHS providers</th>
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<td>7. Productive care</td>
<td>Increase take up of productive ward series; reduce agency staff costs</td>
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<td>8. Back office</td>
<td>Reduce back office spend by 20–30%</td>
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<td>9. Medicines use and procurement</td>
<td>£1m savings per major acute unit, reduce wastage, better cost-effective prescribing</td>
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<td>10. Clinical support rationalisation (pathology)</td>
<td>20% productivity gain through LEAN processes and reconfiguration</td>
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#### Supporting work streams

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<th>11. Primary care commissioning and contracting - technology/digital vision - mobilisation</th>
<th>GMS contract value frozen. Validation exercises to reduce remuneration total</th>
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<td>12. Workforce sickness</td>
<td>Reduce sickness in NHS workforce</td>
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The personal health budgets (PHB) pilot was also launched by the Department of Health in 2009 (http://www.dhcarenetworks.org.uk/PHBLN/). A personal health budget is an important tool for changing the relationship between professionals and those who use services. In Control defines a personal health budget as “an allocation of resources made to a person with an established health need (or their immediate representative)”. On the basis of this resource allocation, an individual develops a support plan which details how the resources will be used to meet his or her identified health needs. Beyond a small number of prohibited items such as alcohol and cigarettes (DoH, 2009), a personal health budget can be used flexibly to provide access to alternative goods and services and to give individuals greater choice over who provides their care and how and when it is provided. The flexibility of the personal budget enables a person’s needs to be seen holistically, potentially reconnecting individuals with their local community and other social networks though community-based activities such as leisure centres and libraries. Individuals are expected to show that they spent their budget in line with their support plan.
Sixty-four PCTs are involved in piloting personal health budgets over three years, of which 20 are taking part in an in-depth, controlled evaluation. A number of evaluation sites have been given the authority to offer a direct payment. Pilot sites are developing personal health budgets for people with various conditions, including individuals with mental health and substance use problems, individuals receiving Continuing Care, maternity services, end of life care, stroke services and those with diabetes. Personal budget holders will be allocated a budget with which to plan their own individual package of care for a certain part of their NHS care.

One important rationale for developing personal health budgets was to create a more patient-centred, responsive NHS. This is reflected in the recent White Paper in which personal health budgets are cited as a means of promoting and extending public and patient involvement and choice in the NHS (DoH, 2010a).

This was reaffirmed by Paul Burstow, Minister of State for Care Services, at a recent personal health budgets conference: ‘...personal budgets encapsulate what we represent. Our single, radical, aim. To change the relationship between the citizen and the state. To do less to people, and more with them. And to ensure Government steps back, making the space for people to lead the lives they want, how they want to. In health and social care, that means giving people real choice over their treatment; real control over how money is spent; and real power to hold local services to account’ (http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117547).

The extent to which personal health budgets support improvements in cost effectiveness in the NHS has been an important question from the outset and is being investigated as part of the national evaluation. Given current financial pressures facing the NHS, the need to examine how personal health budgets could contribute to efficiency improvements in the NHS has become more pressing.

Early findings from the implementation of personal health budgets highlighted concerns among project leads in the individual pilot sites about the funding for personal health budgets. In the current pilot phase, there is often a need to develop personal health budgets alongside existing services rather than dismantling current contracts. This creates financial pressures around double funding, particularly in the current financial climate. Concerns were also expressed about the additional time and staff resources required to support personal budget holders through the planning process (Jones et al., 2010). While it is critical to acknowledge and address these concerns as PHBs move forward, it is also important to recognise that some of these concerns reflect the pilot status of the programme and the need to simultaneously keep existing services running rather than shifting resources to personal health budgets.
The management of patients with long-term conditions, care for older people, reducing avoidable emergency admissions and care for people at the end of their lives have been identified as the biggest ‘efficiency frontiers’ (Dixon, 2010) and these are areas where the development of PHBs is strong. This paper identifies seven potential ways in which PHBs could support the QIPP agenda, identifying specific work streams where relevant:

- improving shared decision-making and responsiveness to individual needs;
- improving health outcomes through genuine co-production;
- developing alternative, less-costly packages of care;
- reducing overall service utilisation through greater prevention;
- increasing competition between providers;
- improving coordination between services; and
- changing professional roles.

Given that most pilot sites are still developing their approach to personal health budgets and have not enrolled many service users, much of the discussion in this paper identifies potential areas for efficiency rather than documenting specific efficiency savings from the PHB pilot site. Before discussing each of the above areas in turn, this paper will assess the evidence on cost effectiveness from social care. While PHBs will differ from personal budgets and direct payments in important ways, the social care experience is an important guide.
The social care experience

The publication of *Putting People First* in 2007 made personal budgets a central pillar of adult social care policy (HM Government, 2007). There are now over 100,000 adults with a personal budget in England, with personal budgets being mainstreamed in 30 councils (Dunning, 2010). This allows for a more realistic assessment of the impact of personalisation than the pilot phase of PHBs when double running costs are a necessity.

Evaluation of In Control’s first phase of work from 2003–2005 identified the largest cost saving in a local authority to be 12 percent. Average cost savings of 9 percent were identified in the second phase of In Control’s work from 2005 to 2007 (Duffy et al., 2008). This led a team from the University of Birmingham to conclude that the roll-out of personal budgets was one strategy for keeping adult social care costs within current limits despite demographic pressures (Glasby et al., 2010).

The latest assessment by John Bolton, former Director of Strategic Finance for social care at the Department of Health is that the roll-out of personal budgets is cost neutral (Brindle, 2010). This echoes findings from the evaluation of the Individual Budget (IB) pilot which concluded that there was little difference in average costs between IBs and conventional support (Glendinning et al., 2008).

Personal budgets in adult social care have a strong track record of improving satisfaction with services and quality of life. Figure 1 reports the satisfaction levels of around 400 personal budget holders with different aspects of their quality of life. More than two-thirds of people using personal budgets report that the control they have over their support (66%) and their overall quality of life (68%) has improved since they took up a personal budget. A majority of people report spending more time with people they want to (58%), taking a more active role in their local community (58%) and feeling that they are supported with more dignity (55%) (Tyson et al., 2010).
Maintaining cost neutrality at the same time as improving quality of life indicates an improvement in efficiency in adult social care services, i.e., greater value is produced for the same amount of spending. This should create some confidence that PHBs can make a similar contribution to efficiency in the NHS.
Routes to efficiency through personal health budgets

1. Improving responsiveness to individual needs and preferences (QIPP work streams 1, 3, 4, 5)

A recent article in the leading US health policy journal, *Health Affairs*, argues for a national policy in support of patient-centred care. The article makes the case that patient-centred care has been shown to lead to better care and to reduce the costs of care. For example, research has demonstrated that enabling patients to actively participate in all aspects of their care, such as choices about treatment and self-management – results in better adherence to medications and improved management of long-term conditions without increasing costs. Furthermore, patient-centred care contributes to patient safety by ensuring that patients’ behaviour, choices and needs are accurately communicated to clinical professionals (Epstein *et al*., 2010).

An earlier literature review of the skills required by patients to manage long-term conditions reached a similar conclusion. ‘The literature indicates that patients who are able to: (1) self-manage symptoms/problems; (2) engage in activities that maintain functioning and reduce health declines; (3) be involved in treatment and diagnostic choices; (4) collaborate with providers; (5) select providers and provider organisations based on performance or quality; and (6) navigate the health care system, are likely to have better health outcomes’ (Hibbard *et al*., 2004).

The positive impact of involving people in their own care has also been demonstrated for vulnerable groups. A randomised, controlled trial involving 160 individuals with a serious mental health condition found that individuals who participated in developing a joint crisis plan together with a care coordinator, psychiatrist and project worker were less likely to be involuntarily treated or admitted to hospital. Individuals who had developed a joint crisis plan also spent fewer days detained in hospital, 14 compared with 31 for the control group (Henderson *et al*., 2004).

Making care more patient-driven is the defining feature of personal health budgets. PHBs tip the balance of power in the relationship between professionals and individuals in favour of individuals and their families. They allow individuals far greater control over the kinds of goods, supports and services they are able to access than traditional NHS service delivery. Even when individuals choose not to change many of the services in their care package, a personal health budget gives them greater choice over who provides a service and how and when it is provided. Having a say over who comes into your home, at what time of day and how services are provided can be critical in enabling people to feel in control of their care.

The importance of these simple choices is illustrated by Debbie and Brian’s story from the Doncaster PHB pilot. Debbie used a personal health budget to develop a care package with resources from Continuing Healthcare for her father, Brian, who had dementia but wanted to remain at home. Brian already had carers visiting four times a day and once at night.
Crucially, the personal health budget allowed Debbie to choose the same care agency and organise care to fit with when she was out at work, out with her son or when she needed general respite. The flexibility of the arrangement meant that Brian’s wish to remain at home was fulfilled and Debbie was able to spend time with her son at the weekend for the first time in two years. Debbie said that her previous experience was of care being ‘done to us’. A personal health budget helped her feel in control and made her and her father feel like valued participants (http://www.dhcarenetworks.org.uk/_library/Resources/Personalhealthbudgets/DebbieBrian_PHB_pilot_story.pdf).

As Debbie and Brian’s story shows, personal health budgets create an important new way to tailor care to meet individual needs and to engage people as active partners in decision-making about their care. Expecting individuals to be active participants rather than passive recipients of services improves health outcomes by promoting resilience and preventing hopelessness. In these ways, there is clear scope for PHBs to support the QIPP agenda.

PHBs could be a particularly important tool for engaging groups that have traditionally not been well served by NHS services and whose outcomes are poor due to a lack of participation in decisions about their care. Inequalities in access to and use of NHS services as well as in health outcomes between the most affluent and most vulnerable in society are well documented (National Audit Office, 2010).

In certain areas of healthcare access for black and minority ethnic (BME) groups is a particular concern, with mental health being a notable problem. A significant part of the problem is the absence of culturally appropriate services and services in the appropriate language. Personal health budgets can create the stimulus for the development of community-based services that are more culturally appropriate, reducing the barriers to take up. Innovation in this area is currently taking place in social care. For example, the Trafford BME Service Improvement Partnership has begun a programme to further develop the black and minority ethnic personal assistant workforce in order to make personal budgets a meaningful option for some people from the diverse communities within Trafford. It will also offer increased employment choices to people from BME communities.

International experience also highlights the opportunities created by personal health budgets to improve service provision for minority groups. In the Cash and Counselling demonstration in the US, a preference survey was conducted among individuals receiving home- and community-based services in each of the three demonstration sites to inform the design of the study. These surveys showed that there was far greater interest in self-direction among non-white compared to white respondents, reflecting greater dissatisfaction with traditional services. For example, in New Jersey, 51 percent of Hispanic and 45 percent of African-American respondents were interested in self-direction compared to 38 percent of white respondents. In California, recipients of long-term care have been able to hire their own personal care workers for many years. As a result, the ethnic make up of the personal care workforce closely matches the ethnic make up of the population (Alakeson, 2007c).
2. Improving health outcomes through genuine co-production (QIPP work streams 1, 3, 4)

One of the central ideas underpinning personal health budgets is that individuals are more than their medical conditions. They may have needs but they also have other strengths and talents to contribute to the partnership alongside professionals. This concept is captured in the idea of ‘real wealth’ which regards financial assets as only one type of individual asset alongside connections, capacities, access and resilience (Crosby and Duffy, 2008). All of these can be drawn on to improve health and wellbeing in partnership with professionals.

By engaging individuals as co-producers in their own care and offering them greater choice and control, PHBs reject the traditional passive view of patients. Instead, patients and service users become part of formulating the problem, identifying potential solutions, establishing outcomes, service delivery and evaluating effectiveness. This is likely in itself to improve health outcomes. Research into the social determinants of health has identified isolation, deprivation and loss of control as having a detrimental impact on individual health (Marmot, 2000). Consequently, one of the six recommendations of the Marmot Review into health inequalities in England was to ‘enable all children, young people and adults to maximise their capabilities and have control over their lives’ (Marmot Review, 2010).

3. Developing alternative, less-costly packages of care (QIPP work stream 1, 3, 4, 6, 7)

Personal health budgets provide individuals with the opportunity to develop alternative packages of care rather than slotting into a set of commissioned services. Figure 2 below shows how participants in the Florida Self-Directed Care (SDC) programme in the Circuit 20 area of the state of Florida spent their personal health budgets (OPPAGA, 2010). Florida SDC began in 2001 and currently serves 330 adults with serious mental health conditions (http://flsdc.org). Uninsured individuals who are not enrolled in the Medicaid programme (the public insurance programme for those on low incomes) receive an annual personal budget of £2,213.76, while Medicaid beneficiaries who choose SDC receive £1,159.72. Participants can use their personal budgets to purchase clinical recovery services, recovery support services and recovery enhancements. Recovery support services are alternative services that are expected to produce the same results as clinical services, for example, massage or weight-loss programmes. Recovery enhancements are goods and services that are expected to enhance a person’s integration into the community through employment, volunteering or socialisation.

The purchasing rules for the Florida SDC programme differ from those for PHBs in England and, therefore, the pattern of spending shown below may vary from purchases made by PHB holders in the NHS. Nevertheless, the diversity of purchases shown in Figure 2 reflects the range of different ways in which individuals can choose to pursue their mental health recovery. As is common in self-directed programmes, there is a clear shift away from healthcare services to community-based activities, many of which are universally provided and require a small fee to participate or are free. As well as being less expensive, participation in community activities at leisure centres, libraries and adult education centres have the added advantage of helping
individuals reconnect with their local community rather than being entirely dependent on services. This can prevent isolation and long-term dependence on services.

**Figure 2:** Percentage spending by category by 97 participants in Florida SDC in Circuit 20 in the first six months of fiscal year 2009-10.

![Pie chart showing percentage spending by category](chart.png)

**Total spending = £58,965.40**

The most significant opportunity to create savings through the development of an alternative package of care exists in the context of residential placements, including out-of-area placements. An example from In Control’s early work in this area illustrates how individuals can have their needs successfully met in the community at far less cost than a residential placement.

Ali is a 16-year-old, physically disabled girl. Her family was struggling to cope with the stress of caring for her and the existing menu of local authority services was not able to provide an adequate solution. This could have resulted in Ali being transferred to a residential setting costing £170,000 a year. Instead, her PCT agreed to contribute £30,000 and her local authority £27,000 to an individual budget that Ali’s family uses to hire four personal assistants to help with her care. The budget allows the family to hire assistants with whom they feel comfortable and who have the specific skills to work with Ali (Alakeson, 2007a).
As part of Stockport Council’s personal budget pilot for mental health, one service user was assessed for an annual personal budget of £35,000. Although this is much above average for the Council’s pilot, it was seen as a cost-effective investment when viewed against other options. The personal budget holder in question had spent 300 days in hospital in the previous five years and the alternative course of action would have been a low-secure unit with an annual cost to the NHS of £120,000. A large investment from social care had the potential to save several times more for the NHS (Putting People First Case Study, 2010).

A PHB could also provide the tailored support to move someone back into the community from a residential placement in or out of the area. This is the approach taken by the Empowerment Initiatives Sustainable Housing Brokerage programme in Oregon, USA. The programme is aimed at young people between 16 and 24 with a mental health condition who are living in a group home or in a psychiatric unit in a hospital and want to move into the community. The programme works with each person to develop a person-centred plan to address their mental health recovery and their transition to independence. Individuals have access to a personal budget and trained peers to support their transition (www.choosempowerment.com). A 2007 comparison of the costs of the programme and the costs of a group home or psychiatric hospital placement revealed that it cost the county between $40,000 and $60,000 a year (£26,000 – £38,000) to house an individual with a serious mental health condition in a group home. The Empowerment Initiatives programme cost $10,000 per person per year (£6,300), including the value of the individual budget, the peer resource broker and the administrative costs of the programme. The housing itself is paid for by the individual and by rent subsidies but is not funded by the health service. Freeing up places in group homes has allowed the county to move people out of the state mental hospital, saving at least $100,000 per person per year (£63,170) (Alakeson, 2007b).

Finally, savings can be made if individuals decide to employ their own staff rather than relying on agency staff. For example, one pilot site has seen savings of 10 percent on NHS Continuing Care packages as a result of families deciding to employ staff directly. Direct employment reduces the overhead charged by agencies for providing the same care (Personal communication with pilot site).

4. Reducing overall service utilisation through greater prevention (QIPP work streams 1, 2, 4)

In many cases, the cost of the package of care purchased with a personal health budget will not be dissimilar to the cost of the package of care formerly provided by the NHS to that individual. However, there are significant opportunities to use the flexibility and person-centred nature of a PHB in a preventative way so as to reduce costs elsewhere in the NHS, particularly the costs of unplanned admissions and use of emergency services.

Evaluations of personal budget programmes in social care in the UK and US have shown improvements in self-reported health and reductions in adverse health outcomes, indicating that health improvement can frequently be pursued through activities outside traditional NHS services (Alakeson, 2010).
An Individual Recovery Budgets pilot conducted by Mersey Care NHS Early Intervention Teams involved 104 individuals over a 12-month period in spot commissioning for mental health: one-off purchases to support individual recovery. Purchases included computer equipment, gym memberships, clothing and transportation and average spending per client amounted to £545.50. Although no systematic evaluation has been conducted of the health impact of the one-off purchases made, a qualitative evaluation highlights examples of purchases that prevented hospitalisation and school dropout and improved self-esteem, community involvement and perceived mental well being. One early intervention worker describes how a laptop and Internet connection prevented an individual from being admitted into hospital by allowing him to remotely keep in contact with staff and others in his circle of support. Without the laptop, staff would not have been able to monitor the person’s well being as he was unable to cope with any in person contact. This would have led to an emergency hospital admission as he would have been considered at high risk of harm (Coyle, 2009).

There may be significant scope for increasing savings of this kind through use of predictive risk models such as the Patients At Risk of Rehospitalisation (PARR) tool that is used by PCTs (Billings et al., 2006). PARR uses routine data to identify patients within a population who are at risk of future admission. Such tools can be used to target interventions, in this case PHBs, to these individuals in the community to reduce avoidable ill health and hospital costs.

5. Increasing competition between providers (QIPP work streams 4, 6, 7, 8)

One of the central policy objectives of personal health budgets was to make providers more responsive to the needs of service users by giving service users the ability to put pressure on providers to develop new services or see custom go elsewhere. This creates a new set of incentives on providers in the NHS since most have not previously faced the real threat of individuals leaving their services. Individual choice has been limited to certain types of services such as choice of hospital for elective surgery. Pressure on providers can have a group dimension to it as individuals can pool their budgets to make larger purchases or commission a service. For example, ten young people receiving services from Solihull’s mental health early intervention team have pooled their direct payments and set up a user-led social enterprise that commission’s services on their behalf and on the behalf of other young people in the early intervention service. Decisions are made by the ten young people who form the organisation’s board in consultation with other service users. Some of the organisation’s money has been used to commission a weekly drop-in that is tailored to the needs and preferences of the young people involved, and also provides a comfortable environment in which other services can be provided, such as psychiatric consultations (Personal communication with Solihull early intervention team).

Since personal health budgets are currently in a pilot phase, their full effect on providers has not been felt because commissioners are not yet moving money out of block contracts and into PHBs. However, anecdotal evidence indicates that PHB holders are choosing not to use providers who are unable to meet their needs, for example, for alternatives to standard residential care placements, and are moving away from the most expensive providers (Personal communication with PBH pilot sites). A closer match between the services individuals want and
the ones that are provided will improve efficiency in the NHS by making it more likely that individuals will engage actively in their care and stay connected to services if they need them.

6. Improving coordination between services (QIPP work streams 1, 2, 3, 4, 5, 6, 7)

Fragmentation, duplication and poor coordination of care are common problems in healthcare and contribute significantly to the costs of the NHS. Personal health budgets can be an important tool for improving coordination at the individual level, particularly between NHS and social care services and in the transition from children’s to adult services. These two areas are discussed below.

Coordination between NHS and social care services

In 2005, the Health Select Committee concluded in its report on NHS Continuing Care that, ‘the question of what is health and what is social care is one to which we can find no satisfactory answer, and which our witnesses were similarly unable to explain in meaningful terms’ (HoC Health Select Committee, 2005). There is a general recognition that the divide between NHS and social care services is an institutional divide and not one with a sound clinical basis, and that there is frequently duplication and confusion at the boundary that leads to additional costs.

In certain areas, such as learning disabilities, mental health and older people’s services, considerable progress has been made in developing joint commissioning and service delivery arrangements. New difficulties were created in the development of health and social care integration by the introduction of direct payments and personal budgets into social care but not into the NHS. The evaluation of the individual budgets pilot that excluded NHS funding highlights the inefficiencies caused by this arrangement. As one project manager stated: ‘It seems we’re very much about health and social care and then there’s this big barrier. It’s all about choice and control until it comes to health. …If we’re talking about the service user or the patient journey it’s like, you know, stop-start, stop-start, because – whereas if health was just in there, it just seems the whole thing would be smoother’ (Glendinning et al., 2008).

The lack of integration with NHS-funded Continuing Care has proven to be particularly problematic. Individuals with well-developed, effective packages of support developed with a social care personal budget or direct payment suddenly lose their entitlement to direct their own support when they become eligible for NHS-funded Continuing Care. This creates major upheaval in people’s lives, forcing them to sack existing staff and accept support from unknown agency staff (see L’s story). Although it has not been documented, this undoubtedly creates inefficiencies in the system.
**L’s Story**

L was diagnosed with Batten Disease at the age of 11. Using a direct payment, L and his family have put together a team of six people who have been working with L for the last six years. The team makes sure that L has a well-planned, active and stimulating week. According to L’s mother, the people in his care team have brought many valuable things to his life, including learning, friendship, care, social interaction, fun, wellbeing, purpose and routine. “We feel these people and the different skills they bring to L are essential to his day, his week and his life.”

L turned 18 this year and will move from children’s to adult services. He has been assessed as being eligible for NHS Continuing Care but this means that he will lose his right to a direct payment and his family will no longer be able to employ the care team that has been caring for him for the last six years. Instead, new agency staff will be sent to care for him. As his mother says, “To discontinue with any of these people at this point in his life could not be in his best interests at all and would indeed be a step backwards with everything he has achieved to date, all of which have gradually become harder for him to maintain. These people have known L from primary school when his speech was normal and his mental state and mobility were good. They formed relationships with him and he with them when he was able to express himself and his opinions clearly and without trouble.

“Bringing new people into his life at this stage, who cannot understand him and have no past experiences or conversation with him is just stressful for him, us, and them. Becoming 18 and going from Children’s Services into Adult or from Direct Payments to Continuing Health Care should surely not mean changing a week that worked perfectly well for him with people he knew, trusted and gained so much from. We do not feel replacement of these people by several strangers in our home is at all beneficial to L or us.”

(Source: Correspondence between In Control and L’s mother)

The development of personal health budgets creates a new opportunity to improve efficiency at the boundary between health and social care. Early research into the use of direct payments in England found that direct payments recipients with complex, high-level support needs frequently used their direct payment to pay their personal assistants to perform health-related tasks. Doing so improved the flexibility and coordination of their care by integrating health and personal care needs. Users in the study wanted direct payments to be formally extended to acknowledge and legitimate the help they were already receiving and to enable them to receive more (Glendinning *et al.*, 2000).

By virtue of being outcomes not services focused, PHBs helpfully erode the distinction between health and social care. For example, an individual may use NHS resources to purchase services that would traditionally be defined as social care or social care resources to purchases services that would typically be provided by the NHS. This is explicitly sanctioned in the Department of Health’s direct payments guidance. ‘In some cases, it may be sensible for a PCT to agree a service which would normally be funded by social care, or another funding stream. If that service is likely to meet someone’s agreed health and wellbeing outcomes, PCTs should not refuse to purchase this because it has been traditionally commissioned elsewhere’ (DoH, 2010c).
In developing packages of care that are needs based and disregard traditional service distinctions, PHBs could improve efficiency across the system.

To maximise the efficiencies that can be created by personalisation, it will be important that local areas develop a unified approach to personal budgets and personal health budgets, including a single assessment framework than can pool or coordinate funding from the NHS and social care and a shared set of agreed outcomes across the two services (Duffy, 2010). Individuals should expect to have only one budget, one plan and one review process to meet their health and social care needs.

**Coordination between children’s and adult services**

As L’s story illustrates, the transition from children’s to adult services can be highly disruptive for individuals and families and can erode the quality of services they receive and lead to a deterioration in health and wellbeing. In some cases, the transition can leave families stranded as there are no suitable adult services in their area. A personal health budget can facilitate a smooth transition as an individual can retain the same support team and day-to-day care routine while the funding source switches from one service to another.

This has been the experience of Mitchell and his family. Supporting Mitchell is highly technical and intensive. Nursing tasks performed safely and well are integral to the support he receives; he has a gastrostomy, tracheostomy and is on long-term ventilation. Using a personal health budget, Mitchell and his family put together a care plan and support team that has been working well and incorporates many of the clinical services he was already receiving, such as weekly physiotherapy from a home care therapist and the services of a home care paediatrician. His team has been carefully chosen and personal qualities were valued over experience. The family looked for intuition, commitment, enthusiasm and fun and found people who embraced the family’s aim of providing continuous, person-centred and high-quality care (http://www.dhcarenetworks.org.uk/PHBLN/Topics/latest/Resource/?cid=7942).

Mitchell has recently turned 18 and there are no adult services in his area to meet his needs. Fortunately, Mitchell’s personal health budget means that the family has not been left stranded. The funding for the personal budget has switched to adult services but his care plan and support team have remained the same (personal communication with Mitchell’s family). Changes only need to be made in response to Mitchell’s needs and the needs of his family, not in response to service boundaries. This creates higher quality, more efficient care. Personal health budgets could be used more widely to support transition from children’s to adult services and, in doing so, could improve efficiency within the NHS.
7. Changing roles for professionals (QIPP work stream 12)

By shifting control to individuals and families, personal health budgets will reduce the need for professionally trained staff. Current care management roles could be undertaken by peer support providers and by independent brokers who are not clinical professionals where individuals choose to be supported in this way. Texas Self-Directed Care, for example, is a personal health budgets programme for individuals with a serious mental health condition in the Dallas area of Texas. It uses trained peers to help participants to develop a support plan and to manage their transactions. Participants can choose to purchase traditional case management if they choose, but few choose to spend their money in this way. Some individuals will not require paid support at all, preferring to be supported by friends and families. Reducing dependence on highly trained staff will lower service costs.

A changing role for professionals may encourage staff retention, thereby reducing the costs associated with recruitment and training. Social workers involved in personal budgets programmes have described how the approach allows them to return to ‘real’ social work rooted in working with individuals to address their needs rather than the administrative tasks that have come to dominate the role. Similarly, studies have shown that workers who are directly employed by service users tend to be satisfied with their jobs. In a survey of direct payment users and staff, 95 percent of personal assistants were happy with their roles and 90 percent felt appreciated either most of the time or frequently (IFF, 2008).
Conclusion

This paper has outlined seven areas where the implementation of personal health budgets could contribute to improving the efficiency of the NHS and the QIPP agenda at the same time as improving the lives of personal health budget holders and their families.

The potential is clear and experience from social care creates a certain amount of confidence that these opportunities can be realised. Over time, it will be important to demonstrate these efficiencies with real evidence and data. Much of this can be done using routine, administrative data related to overall service utilisation and costs and does not require additional investment in infrastructure.

As tax payers and users of the NHS, we all have a vested interest in ensuring that its resources are put to the best possible use to create the biggest possible improvement in people’s health and lives. Keeping people well and in employment, preventing their conditions from deteriorating and avoiding hospitalisation and residential placements by providing effective community-based care are all areas where significant efficiency savings can be made. Personal health budgets have an important contribution to make in all of these areas.
References


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